Office of the Mayor
San Francisco

DIANNE FEINSTEIN

August 27, 1986



George Yamasaki, Jr., President
and Members
Social Services Commission
170 Otis Street
San Francisco, CA. 94103

Dear Mr. President and Honorable Members:

Enclosed please find a copy of the first report of my Committee on Foster Care. This is a preliminary report covering the three areas of inquiry which I assigned for the Committee's investigation and analysis on July 10.

The report provides a disturbing look at some practices and procedures of the Family and Children's Services Division of the Department of Social Services. While the Committee finds that much of the social work practice of the Division that was reviewed was proper and demonstrated a concern for children's welfare, the Committee also finds that in eight of the ten cases of dependent children whose deaths were reviewed, lapses in proper procedure or in judgment by the Department or foster care licensees did occur. In two of the cases, the Committee finds that action or inaction by the Department contributed to circumstances surrounding the deaths.

While this is a preliminary finding, possibly requiring revision when the Committee receives additional data, it also appears that of seven urban California counties surveyed, San Francisco experienced the highest number and rate of deaths of foster and emergency shelter children during the past two years.

The Committee also was charged with making recommendations for change in policies, procedures and practices of the Department. The report lists sixteen recommendations by the Committee, twelve of which require your immediate attention. Key among them are the following:

Development of written protocols for all procedures of the Family and Children's Services Division (hereafter, "the Division");

Development of a clear sign-off procedure for all placement or placement-related decisions of Division staff and committees;

Development of a "vertical care" model for the Division, so that each dependent or potentially dependent child is assigned a worker or supervisor who retains ultimate responsibility for that child throughout the child's dependency, regardless of how many separate units of the Division must handle that child's case;

Improvement of adherence to State guidelines and to standards of proper social work, in such areas as use of properly certified or licensed homes, pre-placement visits, criteria for removal of dependents from foster homes, criteria for effective monitoring of foster homes, and regular staff review of dependents' deaths;

Recruitment of foster homes in San Francisco, with special attention to ethnic minority homes and homes suitable for medically fragile and failure-to-thrive infants and children.

The Committee also makes four recommendations for the State Department of Social Services to consider, and I commend these to your attention.

In concluding, let me state emphatically that there should be no business as usual. The Commission and General Manager should immediately begin a major evaluation and reorganization of the Family and Children's Services Division. Personnel performance must be carefully reviewed and appropriate action promptly taken. Supervision and direction must be properly assessed and strong supervisory directives established. I am asking the Commission and the Department to enter forthwith into a major reassessment of all practices of the Family and Children's Services Division, including case supervision, monitoring of placements, staffing, and training.

I am requesting that the Commission and General Manager accomplish this reassessment and reorganization within sixty days. At the conclusion of that period of time, I will ask my Committee on Foster Care to select an independent firm to perform an in-depth review and evaluation of the Department's achievements in improving the operations of the Family and Children's Services Division. I would expect the evaluators to take their guidance from the Committee and my office and to report to both the Committee and to your Commission. Funds for this activity would come from the Department's budget, and the Department would contract for the work.

In closing, I urge you to study the Committee's report and to consider the implications of its findings for the welfare of infants and children under the Department's care.

Sincerely,

Dianne Feinstein, Mayor
7520U
DF/TA

enc.

Office of the Mayor
San Francisco

DIANNE FEINSTEIN



August 26, 1986

The Honorable Dianne Feinstein
Mayor
Room 200, City Hall
San Francisco, CA 94102

Dear Mayor Feinstein:

Enclosed herewith please find the first report of your Blue Ribbon Committee on Foster Care. While the Committee members and I believe that we have achieved significant insight into the subject areas you assigned for investigation, we request that this be considered a preliminary report to you. Further work needs to be done in at least two of the areas covered: foster care death rate comparisons among counties, and foster care practices and procedures in the Department of Social Services.

The report contains three sections, corresponding to the three charges you gave to the Committee. The first section covers our efforts to compare the foster care death rates among seven large California counties. We have discovered that there is little standarization in reporting of strictly foster care and emergency shelter care deaths in California, and consequently we will be continuing to gather information from a variety of sources. At first glance, it does appear that in the two-year period we studied (July 1, 1984 - June 30, 1986), San Francisco's death rate among children in emergency shelter and foster care exceeded that which was reported by the other counties surveyed.

The second section examines the deaths of ten children, all but three of whom died between July 1, 1984 and June 30, 1986. All were in foster care or emergency shelter care under jurisdiction of our Department of Social Services. Information is given on the cause and manner of deaths, the suspiciousness of the deaths, the circumstances surrounding the deaths, and the appropriateness of care given to the children.

The third section highlights areas of departmental policies, practices and procedures which came into focus during our investigation of the ten deaths. As you will see, we believe that several areas of departmental responsibility require further study and improvement. The Department of Social Services can improve its procedures in several areas related to foster and emergency shelter care, and may thereby reduce the rate of suspicious and accidental deaths among this population of children.

You will also find that we have made recommendations pertaining to matters of State jurisdiction, and to matters of abuse of children in emergency shelter and foster care. While these matters were not included in your charge to us, we find that abuse of foster children-as distinct from the death of foster children-and the licensing and monitoring of foster homes by the State are two areas that do require attention.

The Committee proposes negotiations with qualified parties, such as the American Humane Association, whose principals have no recent or present business relationship with the Department of Social Services, and who can initiate a comprehensive review and analysis of foster care and emergency shelter care policies, procedures and practices of the department. The Committee feels that we need outside expertise to complete this charge to us. We propose that the third party contractor performing this work be selected by and take general guidance from the Committee and report to the Committee and the Social Services Commission.

We have appreciated the opportunity to undertake this investigation on your behalf and we look forward to meeting with you again in the near future.

Sincerely,

Francis W. Mayer

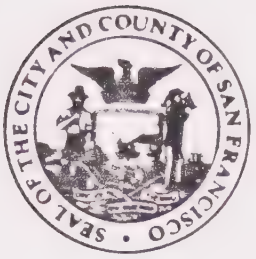
Judge Francis W. Mayer
Chairman

Kathy Baxter-Stern, Member
Christopher Emley, Member
Moses Grossman, M.D., Member
Carol A. Johnston, Member
Michael Lenoir, M.D., Member
Boyd Stephens, M.D., Member

FWM/TA:avt

7488U

Office of the Mayor
San Francisco




DIANNE FEINSTEIN

# DEATHS OF CHILDREN IN FOSTER CARE AND EMERGENCY SHELTER CARE

## A PRELIMINARY REPORT

AUGUST 26, 1986

MAYOR'S COMMITTEE ON FOSTER CARE

JUDGE FRANCIS W. MAYER, CHAIRMAN



REPORT PREPARED BY:

TIMOTHY ARMISTEAD
STEPHEN LA PLANTE

MAYOR'S COMMITTEE ON FOSTER CARE

JUDGE FRANCIS W. MAYER, CHAIRMAN

KATHY BAXTER-STERN
CHRISTOPHER EMLEY
MOSES GROSSMAN, M.D.
CAROL A. JOHNSTON
MICHAEL LENOIR, M.D.
BOYD STEPHENS, M.D.

STAFF:

ROTEA J. GILFORD
JAMES BUICK
TIMOTHY ARMISTEAD
STEPHEN LA PLANTE
ZORAINA JAMES

TABLE OF CONTENTS

Executive Summary . . . . . 2 - 8

Introduction . . . . . 9

Death Rate Comparison . . . . . .10 - 12

Investigation of Ten Deaths . . . . . .13 - 30

Persons Interviewed by Committee or Staff . . . . . .31 - 32

## EXECUTIVE SUMMARY

This report discusses the Committee's preliminary findings in three areas of concern, as requested by Mayor Feinstein:

I. Comparison of Foster Care and Emergency Shelter Deaths, San Francisco and Selected Counties, July 1, 1984 through June 30, 1986:

The Committee compared the number and rate of foster care and emergency shelter care deaths in San Francisco and six other urban California counties during the past two years. The results are preliminary and may need revision when additional data are received regarding the six comparison counties. At the time of this writing, it appears that while San Francisco ranks fifth among the seven counties in total residential population, third in foster care caseload and fifth in emergency shelter admissions, it ranks first in number of deaths during the study period (8 vs. average of 3) and in rate per 1,000 foster care cases (2.91 vs. average of .98).

II. TEN FOSTER CARE/EMERGENCY SHELTER DEATHS

The Committee investigated seven of the eight deaths* that occurred during the two-year study period and three deaths that occurred earlier (two in 1981, one in 1982). The Committee finds that in two of the cases, action or inaction by the Department of Social Services contributed to circumstances surrounding the deaths. In four deaths, troublesome departmental practices contributed less directly to circumstances in which the children died. In two additional deaths, legal and customary departmental actions which the Committee feels require revision may have exposed the children to risks that could have been avoided. In the two remaining cases, departmental procedure was entirely proper except for the failure to staff the deaths. (None of these deaths was the subject of a staff review by the Department, an omission we recommend be corrected in the future.)

* The Committee briefly reviewed an eighth death that occurred during the study period. It was the natural death of a severely handicapped male who had long been in foster and institutional care. The Committee determined that it raised no issues of care or procedures, so it was not investigated further.

## III. RECOMMENDATIONS FOR CHANGE OF POLICY, PROCEDURES, AND PRACTICE:

The Committee is not in a position at this time to make comprehensive and detailed recommendations for improvement in departmental emergency shelter and foster care practices. We have seen, however, that certain basic issues surface repeatedly in our investigation of the ten deaths. We believe that the third mandate for our Committee - to review and make recommendations for policies, procedures and practices related to placement of dependent children - is best served by a dual approach.

First, we list below recommendations that we are confident can and should be studied, refined, and implemented by the Department of Social Services as soon as possible. Second, we recommend that independent consultants be retained to perform a comprehensive review of emergency shelter and foster care practices and procedures of the department, and that this review be done under the authority of the Mayor's Office and this Committee. Following this comprehensive review, the Committee will issue its final report.

Our recommendations for improvement in departmental practices are listed below in four categories:

### A. INTERNAL DEPARTMENTAL MATTERS

1) Formal training should be standardized and given to all new workers who have responsibility for dependent children. The training should cover, at a minimum, State regulations and guidelines, SB 14, community resources, departmental policies and procedures, techniques for monitoring and evaluating quality of child care, and basic emergency medical procedures. Update training should be given on an annual basis to all experienced workers and supervisors. Currently, according to the Child Welfare Division Manager, most training is by word-of-mouth and by pairing of new with experienced workers.

2) Written protocols should be developed for all emergency interventions, pre-placement, placement, and follow-up procedures. These should include protocols for on-site monitoring of placements. The protocols should be made available to all workers in three-ring binder format to allow for revisions and should be made one of the subjects of formal training. Currently, no repository of protocols and policies exists in handbook form.

3) The Department should devise a system whereby each dependent or potentially dependent child is assigned to a worker or supervisor who retains ultimate responsibility for that child throughout the child's dependency. Currently, no one worker or supervisor need feel that he or she bears ultimate responsibility for a dependent child, since each child's case progresses through several units of the Child Welfare Division. This has resulted, in some cases, in confusion and misinterpretation among DSS workers to the detriment of the clients. A related component of this recommendation is that a clear sign-off procedure be developed for each phase in a child's progress through the Division.

4) The span of control in the Child Welfare Division may be too broad to be practicable. Consideration should be given to greater delegation of responsibility and authority.

5) Major re-organizations of the Division and reallocation of staff among its units should be reviewed and approved by the General Manager prior to implementation. Standards for advancement and rotation of staff should be prepared by the Department and approved by the Social Services Commission.

6) The Division should review and improve its compliance with state regulations and good social work practice regarding timeliness of placement visits, use of only licensed or certified homes for placements, selection of appropriate homes for medically fragile infants, criteria for removal of children from foster placements, and related matters.

7) The Department should staff all deaths and abuse of dependent children in its jurisdiction. The staffing should include a review of all reports, records, and

interviews pertaining to the death or abuse. Its focus should be on determining whether the event was in any sense suspicious, whether proper placement and follow-up procedures had been followed, and wnether licensees' reports of the events surrounding the event are internally consistent and are consistent with medical reports, emergency dispatch records, and so on. Except in the clearest cases of natural death, further placements to the facility in which death or abuse occurred should not be made until the review is complete and satisfies the Department as to the licensees' adequacy of care.

B. RELATIONS WITH OTHER AGENCIES AND WITH LICENSEES

8) The Department should review its practices and procedures in the use of home finding agencies and out-of-county placements. Of the seven suspicious deaths investigated, four occurred in out-of-county placements. Four of the ten deaths occurred in homes licensed by agencies other than the department. When placements are recommended by an outside agency, DSS should be required to review the home study and all documents pertaining to the home study and to the criminal records check of the prospective parents.

9) An independent management and program evaluation of Children's Home Society should be completed. The Department has depended heavily on CHS for emergency shelter of dependent children for the past five years. Sufficient concerns were raised by our investigation of two deaths of CHS-placed infants to warrant an examination of CHS practices and procedures.

10) The Department should vigorously recruit foster parents in the City. This may require allocation of additional personnel to recruitment and to processing of applications. Special attention should be given to recruitment of ethnic minority homes and homes suitable for medically fragile and failure-to-thrive infants.

11) The Department should institute more rigorous monitoring of foster care and fost/opt licensees. Of particular importance are the following areas:

a) face-to-face pre-placement visits to all licensees;

b) ensuring that licensees are competent in handling emergency medical situations;

c) maintenance of a schedule of site visits, including week-end visits and visits to out-of-county placements.

d) ensuring that licensees' backgrounds do not impact adversely on their care or supervision of children.

C. DSS WORKERS' CARE OF DEPENDENT CHILDREN

The Committee discovered abundant evidence of the genuine concern of social workers for their young clients. There is no doubt that as individuals, the majority of social workers whose work we reviewed took pains to provide every measure of protection for dependent children. Nonetheless, the Committee finds that a basic issue must be addressed regarding direct contact between social workers and the children:

12) So long as DSS uses placements supervised by home finding agencies, it must recognize that ultimate responsibility for the child in such placements still rests with the Department. The Department must not allow either the geographical location or the source of the placement to impede site visits to the home or direct contacts with the children and foster parents.

D. RECOMMENDATIONS FOR STATE LICENSING PROCEDURES

In our review of the ten deaths, it became clear to the Committee that some of our misgivings about care of dependent children in emergency shelter require action by the State in order to be allayed.

Four specific issues have been mentioned by our staff to the State investigative team that studied most of the same deaths we examined. Members of the State team considered them worthy of consideration by State DSS.

13) Regulations or guidelines should be developed to specifically safeguard the health of positive drug toxicity infants and other infants in whom risk of SIDS is statistically greater than normal. At a minimum, these guidelines would include the requirements to verify by sight or touch, at regular intervals at night, that the infant is breathing in a fashion normal for that infant; the requirement that CPR and resuscitation of infants be current skills of licensees (periodic demonstrations of technique by

licensees should be required, even after certification in these areas); and the requirement that licensees understand proper procedure for notification of medical personnel and DSS staff of medical emergencies or illnesses.

14) The State should take care to ensure that licensees' religious or other ideological beliefs and observances do not lessen the quality of care or supervision in their homes. This may mean that licensees who strictly observe sabbath restrictions or ceremonies should be required to make special care arrangements during and/or after their sabbath.

15) The State should consider implementing a routine, formal death review process at the State level, along the lines of our recommendation in section I above.

16) In granting foster home licenses, the State should consider guidelines regarding the need for licensees and their paid staff to be sufficiently fluent in English to communicate quickly and effectively in emergencies.

## IV. CONCLUSIONS

The provision of emergency and long-term care to dependent and prospective dependent children often is complex, adversarial and emotionally taxing. The Committee appreciates the enormous burden this can place on all the principals - natural and foster parents, the infants and children, attorneys, the Court, and social workers.

The ultimate purpose of our investigation was to determine whether the enormity and complexity of the mandate to provide care and safety to dependent children may have overwhelmed the Department of Social Services in the case of some of its clients. We find that this did occur.

In the case of two of the ten children studied (Cases 4 and 5), there is no doubt that departmental errors in judgment and in procedures contributed to the circumstances leading to the children's deaths. In four of the other cases studied (#'s 3, 6, 8 and 9) troublesome procedures and practices were determined to have occurred which contributed less directly to circumstances in which the children ultimately died. Even where basic placement procedures were followed (Cases 1 and 2) we found practices by the Department or its emergency shelter contractor which, if

revised, may have provided a greater measure of safety for the children. In two cases of the ten (7 and 10), Department procedures were completely sound except for the failure of staff to review the deaths.

The Committee hopes that the recommendations contained in the previous section of this report will be studied, revised if necessary, and implemented as soon as practicable.

## INTRODUCTION

On July 10, 1986 Dianne Feinstein appointed a Committee on Foster Care to investigate the City's placement of difficult-to-place children in foster homes. Three specific charges were given.

1) Compare death figures in San Francisco foster homes with those of other urban counties;

2) Investigate the deaths of any children in foster care over the last two years;

3) Review and make recommendations for change in the practices, policies and procedures of the Department of Social Services in placing difficult-to-place children in foster care.

This constitutes the Committee's first report of findings in these three areas of responsibility. While our findings in areas #1 and #3 above are very preliminary, the committee believes that its review of area #2 is complete and is capable of addressing the Mayor's major concerns regarding the deaths of seven children during the period July 1, 1984 through June 30, 1986, and the deaths of three children that the Committee selected to investigate despite their having occurred in earlier years (two in 1981, one 1982).

## DEATH RATE COMPARISON

Comparing urban California counties' mortality rates and raw death figures of foster care and emergency shelter care children is a difficult task. The State collects death figures of children in court ordered placement, but these figures include categories of youths other than dependents in foster care or shelter care, and separating out the deaths that concern us has proven difficult. On the local level practices vary among pediatricians and social services departments in reporting of children's deaths to coroners, so we cannot be certain that locally-derived figures are comparable either.

The Committee has contacted key social services staff in each of six large California counties and has obtained from them foster and shelter care caseload figures and, to the best of their knowledge, death figures among this population of children. While the figures appear consistent with state figures, we are currently contacting coroners in each of the six counties to determine whether they know of additional deaths of dependent children which should be included in the totals. In this way, we will ensure having conducted the same search for data in the comparison counties as we conducted in San Francisco.

Table I, following, lists seven California counties in order of their current population. San Francisco ranks fifth out of the seven in total population, third in total foster care during the study period, fifth in emergency shelter care admissions, but first in number of deaths. San Francisco also ranks first in the rate of deaths per 1,000 children in foster care during the study period.* Finally, the figures indicate that San Francisco ranks first in raw figures (8 deaths vs. average of 3) and in rate/1,000 (2.91/1,000 vs. average rate of .98/1,000) by a substantial margin.

By way of attempting to establish a larger base mortality rate, the Committee sought national data on deaths of infants and children. At the time of this writing we have not discovered national data bases of sufficient comparability to use in this report.

---

* The base to which deaths was figured should logically include emergency shelter admissions, but these are duplicative of foster care caseload figures to an unknown degree. In any event, figuring deaths to a combined base of foster care and emergency shelter caseloads does not alter San Francisco's death rate ranking.

When the Committee has received and analysed county coroners' figures (as well as figures from other sources we have approached) we will issue an update for this section of the report.

TABLE I *

DEATHS OF FOSTER AND EMERGENCY SHELTER CARE CHILDREN

JULY 1, 1984 - JUNE 30, 1986

| COUNTY | COUNTY ** POPULATION/RANK | TOTAL IN *** FOSTER CARE/RANK | TOTAL IN EMERGENCY SHELTER/RANK | TOTAL | DEATHS RATE/1,000 IN FOSTER CARE | RANK |
|---|---|---|---|---|---|---|
| ALAMEDA | 1,197,000/1 | 3,350/2 | 6,141/1 | 3 | .90 | 4 |
| SANTA CLARA | 1,400,100/2 | 5,200/1 | 3,468/2 | 3 | .58 | 6 |
| SACRAMENTO | 893,800/3 | 2,722/4 | 3,343 (est.)/3 | 3 | 1.10 | 3 |
| RIVERSIDE | 820,600/4 | 1,872/6 | 2,727/4 | 1 | .53 | 7 |
| SAN FRANCISCO | 735,000/5 | 2,748/3 | 2,485/5 | 8 | 2.91 | 1 |
| CONTRA COSTA | 717,600/6 | 2,000 (est.)/5 | 2,377/6 | 3 | 1.50 | 2 |
| SAN MATEO | 616,600/7 | 1,199/7 | 1,440/7 | 3 | .76 | 5 |

* Death and death rate figures are tentative, pending further data.

** Population figures from State of California, Department of Finance, July, 1985.

*** Foster care, emergency shelter care, and death figures from social services staff of respective county departments.

## INVESTIGATION OF TEN DEATHS

The Committee investigated seven deaths of children in emergency shelter or foster care during the study period.* Additionally, we decided to investigate the deaths of three children from earlier years in order to determine whether the circumstances surrounding those deaths bore similarities to the more recent deaths. Our investigation included review of all social services and Court files for each child; review of hospital, coroners', and police inspectors' reports where available; and in case numbers 2 and 6, interviews of medical, social services and law enforcement personnel connected with the cases.

A primary objective of the Committee was to determine which of the deaths were suspicious. For a death to be suspicious in the Committee's view, it is not necessary for it to be a case of suspected homicide, non-negligent manslaughter, or negligence. It is sufficient that circumstances surrounding the care of the child before, during or immediately after a health crisis be questionable for us to define the death as suspicious.

Of the ten deaths studied, we consider seven to be suspicious, six of which occurred in the two-year study period. Of the three non-suspicious deaths, one occurred during the study period and two occurred in 1981. In short, the Committee finds that six of the seven deaths of children in emergency shelter or foster care during the recent two-year period are suspicious.

The Committee also finds that even in cases of non-suspicious deaths, certain procedures and practices of the Department of Social Services require correction. In eight of the ten cases we found DSS practices and procedures to be questionable to a greater or lesser degree; in two cases, procedures were sound except for the failure of the Department to review the deaths.

Information on the ten deaths is presented below in two formats. First, Table II summarizes key information regarding each case. By perusing this table the reader can determine quickly whether the child had been placed in the county; the cause and manner of death; whether the death was suspicious; and whether the placement and follow-up of the case by DSS was appropriate.

Second, each case is presented in brief narrative form following Table II.

The cases are listed by number in order to preserve confidentiality. Cases 1-6 and 8 are considered suspicious; 7, 9 and 10 are considered to be not suspicious. The numbering is consistent between Table II and the case narratives that follow Table II.

---

* See footnote, page 3.

TABLE II

PRELIMINARY ANALYSIS OF DEATHS OF
DEPENDENT CHILDREN

| CASE NUMBER | RACE/ SEX | DATE OF DEATH | AGE | IN OR OUT OF COUNTY | MANNER/ CAUSE OF DEATH | WAS DEATH * SUSPICIOUS | WAS HOME SUITABLE | PROCEDURES FOR PLACEMENT FOLLOWED | DSS FOLLOW-UP AND REPORTING PROCEDURES |
|---|---|---|---|---|---|---|---|---|---|
| 1 | B/F | 3/13/85 | 17 mos | Out | Homicide. Blunt trauma to head and torso. | Yes. Local PD reopened case due to our inquiry. Presently 2 primary suspects and 3 secondary suspects. | Yes. Placement was appropriate based on information available at time of placement. | Yes. Pre-placement home visit conducted by SFDSS; foster home properly certified by SFDSS; home study completed by county of placement. | SFDSS arranged for and carried out monthly visits with natural mother and infant at SFDSS office, but no home visits made by DSS during placement. Such visits currently not required by law. DSS failed to staff death or circumstances surrounding it. |
| 2 | B/M | 2/23/86 | 1 mo | Out | Pending. | Yes. Unclear how carefully infant was checked at night. Unclear how long licensees waited subsequent to infant's death before seeking medical assistance. | Yes. Was a state licensed small family foster home. | DSS procedures for emergency placement to CHS appear proper. | Prior to death, CHS has no record of in-home visit. CHS failed to provide required written information to home regarding DSS and CHS emergency contact persons and telephone numbers. DSS and CHS failed to staff death or circumstances surrounding it. |

* Suspicious, as used in this report, connotes any death in which care of the child immediately before, during or after the child's medical crisis was questionable in some regard.

TABLE II

PRELIMINARY ANALYSIS OF DEATHS OF DEPENDENT CHILDREN

| CASE NUMBER | RACE/ SEX | DATE OF DEATH | AGE | IN OR OUT OF COUNTY | MANNER/ CAUSE OF DEATH | WAS DEATH SUSPICIOUS | WAS HOME SUITABLE | PROCEDURES FOR PLACEMENT FOLLOWED | DSS FOLLOW-UP AND REPORTING PROCEDURES |
|---|---|---|---|---|---|---|---|---|---|
| 3 | W/F | 1/3/82 | 3 mos. | IN | Homicide. Dehydration and malnutrition due to parental neglect. | Yes. Natural mother charged with invol. manslaugther. Found incompetent to stand trial, committed to Patton State Hospital; DA dismissed case in exchange for conservatorship, 6/10/85. | No. Was placed with natural parents, mother chronic psychotic, father alcoholic who failed to perform required supervison of child. | Yes. DSS appeared to have followed accepted guidelines, Court commissioner returned child to natural parents from DSS shelter placement; uncertain whether this return was negotiated disposition or result of contested hearing. | DSS made 4 home visits (11/4, 11/20, 11/24, 12/18), seized infant on 11/24. Infant returned to natural parents by Commissioner on 12/8. DPH nurses had made numerous visits in October and November, fewer in December due to reclacitrance of mother. Warrant to seize infant requested by DSS and issued 12/30/81; warrant assigned to Lt. by Northern Station Captain on 12/31; homicide inspector recalls there was effort to serve warrant but no answer at the door. On 1/4/82, 1 day subsequent to infant's death, DSS worker advised SFPD that memo assigning service of warrant listed wrong address for infant. |

TABLE II

PRELIMINARY ANALYSIS OF DEATHS OF DEPENDENT CHILDREN

| CASE NUMBER | RACE/ SEX | DATE OF DEATH | AGE | IN OR OUT OF COUNTY | MANNER/ CAUSE OF DEATH | WAS DEATH SUSPICIOUS | WAS HOME SUITABLE | PROCEDURES FOR PLACEMENT FOLLOWED | DSS FOLLOW-UP AND REPORTING PROCEDURES |
|---|---|---|---|---|---|---|---|---|---|
| 4 | W/M | 3/6/85 | 9 mos. | IN | Unknown. Marked pulmonary hyperemia with edema, cutaneous tissue showing increased pigmentation of basal layer | Yes, but homicide investigation exonerated the only suspect. | No. A previous voluntary placement with maternal grandparents was questionable, and subsequent return of infant to natural home by DSS was error in judgement. | No. Proper social work judgement would have dictated filing of a petition and placement out-of-home. | DSS worker responsible for case given 30-day suspension for improper procedures. DSS failed to staff death or circumstances surrounding it. |
| 5 | B/M | 6/13/86 | 14 mos | OUT | Homicide. Extensive blunt trauma to head and body. | Yes. Foster parents arrested for murder; case pending. | No. | No. Homefinding agency inadequately researched family and failed to obtain waiver of criminal history of one licensee. DSS failed to monitor homefinding agency properly, failed to follow clear placement procedures, failed to perform pre-placement visit, failed to properly license home for DSS use. | DSS failed to adequately investigate report that foster mother was transvetite and hence had falsified application to homefinding agency. DSS did conduct two home visits subsequent to placement. The second visit was made later than required by regulations. DSS failed to staff death or circumstances surrounding it. |

TABLE II

PRELIMINARY ANALYSIS OF DEATHS OF DEPENDENT CHILDREN

| CASE NUMBER | RACE/ SEX | DATE OF DEATH | AGE | IN OR OUT OF COUNTY | MANNER/ CAUSE OF DEATH | WAS DEATH SUSPICIOUS | WAS HOME SUITABLE | PROCEDURES FOR PLACEMENT FOLLOWED | DSS FOLLOW-UP AND REPORTING PROCEDURES |
|---|---|---|---|---|---|---|---|---|---|
| 6 | B/F | 6/23/86 | 5 mos. | OUT | Pending. Resp.arrest, renal failure cited as conditions prior to death. | Yes. Unclear how carefully infant was checked at night. Apparently inappropriate resuscitation used by licensee. | Yes; was a state-licensed small family foster home. | DSS procedures for emergency placement to CHS appear proper. | Prior to death, CHS arranged for several visits at SFCHS between infant and natural family; CHS also performed some in-home visits. CHS failed to provide required written information to licensee regarding DSS and CHS emergency contact persons and telephone numbers.<br><br>DSS and CHS failed to staff death and circumstances surrounding it. |
| 7 | B/F | 11/30/81 | 2 mos | OUT | SIDS | No. | Yes. | Yes. | Reporting procedures proper; DSS failed to staff death or circumstances surrounding it. |

TABLE II

PRELIMINARY ANALYSIS OF DEATHS OF DEPENDENT CHILDREN

DATE: 8-15-86

| CASE NUMBER | RACE/ SEX | DATE OF DEATH | AGE | IN OR OUT OF COUNTY | MANNER/ CAUSE OF DEATH | WAS DEATH SUSPICIOUS | WAS HOME SUITABLE | PROCEDURES FOR PLACEMENT FOLLOWED | DSS FOLLOW-UP AND REPORTING PROCEDURES |
|---|---|---|---|---|---|---|---|---|---|
| 8 | W/F | 7/17/85 | 2 1/2 Yrs. | IN | Accidential drowning in bathtub. | Yes. | Yes. | Placement was court-ordered, though no record exists that foster care license had been granted or home study done at time of placement. | SFDSS staff cited a non-existent medical disorder as cause of death in its reports to State DSS. SFDSS, shortly after child's death, moved to license home for another placement. No evidence on file that DSS counseled adoptive parents in remaining with a toddler who is being bathed. |
| 9 | B/F | 3/31/81 | 8 mos. | IN | Died after surgery to correct congenital defects. | No. | Home not suitable; not licensed at time of placement. Infant probably should have been placed in special medical needs home. DSS worker's file indicates infant's doctor felt medical care by foster mother was good, however. | Yes. Record on file that court ordered the placement; home not licensed, however. | Yes. DSS maintained contact with the foster mother and the infant's doctors. DSS failed to staff death and circumstances surrounding it. |

TABLE II

PRELIMINARY ANALYSIS OF DEATHS OF
DEPENDENT CHILDREN

| CASE NUMBER | RACE/ SEX | DATE OF DEATH | AGE | IN OR OUT OF COUNTY | MANNER/ CAUSE OF DEATH | WAS DEATH SUSPICIOUS | WAS HOME SUITABLE | PROCEDURES FOR PLACEMENT FOLLOWED | DSS FOLLOW-UP AND REPORTING PROCEDURES |
|---|---|---|---|---|---|---|---|---|---|
| 10 | A/F | 1/9/85 | 1 yr. | OUT | Natural death; heart failure after surgery for heart abnormalities; Downs syndrome child. | No. | Yes - licensed foster home with long history of numerous placements. | Yes - placed by CHS. | Mother relinquished child to CHS. No need for DSS follow-up. DSS failed to staff death or circumstances surrounding it. |

## DEATH NARRATIVES

| | |
|---|---|
| Case: | #1, Black female infant |
| Born: | October 8, 1983 |
| Died: | March 13, 1985 |
| Legal Status: | Child born to chronic alcoholic mother. Father incarcerated in state prison and had never seen her. On 2-5-84, mother was booked for burglary. SFPD officers found child with five-year old brother alone in their apartment. Both children placed in shelter. Baby was classified as a "failure to thrive" infant. Mother consistently failed to carry out any of the service agreements or court orders regarding actions needed for reunification. #1 finally placed in a fost/opt home out of county on 12-14-84. |
| Cause of Death: | Homicide. Blunt trauma to head associated with blunt trauma to torso. |
| Case Summary: | Placement appeared to be appropriate based upon extensive information available to Contra Costa County social worker. Foster mother would leave child each work day with a babysitter who believed baby was possessed by the devil and who allegedly practiced exorcism on the child. On 3-12-85, baby supposedly fell from potty chair catching her leg. Foster mother claims to have picked up the baby to calm her but noticed baby was lethargic. She stated she severely shook baby to prevent sleep. Baby stopped breathing. Child taken to the hospital, then flown by helicopter to higher level care facility. Child later transferred to another medical facility where she died the following day of multiple traumatic injuries. |

| | |
|---|---|
| Case: | #2, Black male infant. |
| Born: | January 24, 1986. |
| Died: | February 23, 1986. |
| Legal Status: | Placed in same six-bed emergency shelter foster home as #6, at 14 days of age, under jurisdiction of DSS and Children's Home Society. |
| Cause of Death: | Final results pending. |
| Case Summary: | #2 originally was recommended by DSS worker for placement in his own home under care of his father. SFGH refused to release #2 to father, however, citing smell of alcohol on father and natural mother's history of narcotics abuse. (#2 was born with positive drug toxicity test results.) #2 was placed in emergency foster care as a well baby with minor symptoms of drug withdrawal, pending hearing on court dependency and placement. Infant's natural parents reportedly prepared home hoping for return of infant. DSS case worker appeared to favor family reunification as final resolution of case.<br><br>#2 died some time during the early morning hours of February 23, 1986. While no responsibility for #2's death is being fixed on foster licensees, there are some unresolved questions regarding the appropriateness of care and emergency procedures at the foster home in the hours preceding and after #2's death. Medical help was not sought by licensee until 11:16 a.m., despite having allegedly found baby cold and rigid at between 9:30 and 10:30 a.m. Responding paramedic nurse reports that at 11:18 a.m. #2 was extremely cyanotic, was in full rigor mortis and must have been dead for about two hours, in paramedic's opinion. As with the infant #6, #2 may not have been fed since approximately midnight. (On this and other issues, the licensees' stories reflect significant discrepancies that have not been resolved.) |

Case: #3, White female infant

Born: October 7, 1981

Died: January 3, 1982

Legal Status: Baby was born prematurely to chronic psychotic mother; DSS Emergency Services notified; no petition filed due to support of the father who promised not to leave baby alone with mother; father was unemployed and an alcoholic; baby seized by DSS worker with police assistance on 11-24-81 due to instability of mother and absences of the father; petition under Sec. 300(a) filed on 12-2-81; contested hearing held 12-8-81 and baby returned to natural parents; warrant issued for baby on 12-30-81 by Juvenile Court because parents refused to obey court orders from 12-8-82 hearing; request to Northern Station to serve warrant was received by Northern on 12-31, with incorrect address on it; baby found dead on 1-3-82; DSS worker notifies SFPD liaison 1/4/82 that SFPD had wrong address, and requests SFPD serve at correct address.

Cause of Death: Homicide. Dehydration caused by parental neglect.

Case Summary: On 12-31-81, father left home to go to a friend's house; apparently became intoxicated and did not return home until 1-3-82 when he discovered child had died; mother was angry at father and left home on 1-1-82 leaving baby unattended; left town and did not return until 1-5-82 when she was booked for involuntary manslaughter. Baby died of dehydration and malnutrition due to neglect by the mother; father not charged because mother was last adult to leave child. Mother was found mentally incompetent to stand trial and committed to state hospital. District Attorney finally dropped charges on 6-10-85 in exchange for initiating conservatorship proceedings. Father had been known by DSS to have failed to uphold his agreement to care for child and not leave child alone with mother. It was on that

basis that warrant was issued on 12-31, but the warrant was not walked through the system to ensure speedy service, as should have been done in this case. Additionally, request to Northern Station for warrant service listed incorrect address. Committee not certain at this date whether service ever attempted at correct address; Committee not certain of source of incorrect address.

Case: #4, White male infant

Born: May 24, 1984

Died: March 6, 1985

Legal Status: Juvenile Court never involved with this case. Nurse at local clinic made initial referral for neglect on 6-18-84; referred to Child Protective Services. On 8-20-84, baby admitted to SFGH; again, referred to Emergency Services; again, decision made to have CPS monitor with seven conditions. On 1-23-85, mother arrested on drug charges; mother asked her parents (out of county) to take #4, against wishes of presumed father; considered a voluntary placement.

Cause of Death: Unknown. Died of pulmonary hyperemia with edema.

Case Summary: Child born to teenage mother with history of drug abuse and prostitution since age 14; older brother was age 2. Baby was "failure to thrive" infant. Mother and presumed father lived in City subsidized homeless hotel. DSS child protective worker ordered baby returned to SF from grandparents' home on 3-4-85, after receiving doctor's request to see infant 3-8-85. #4 was placed with presumed father on 3-4-84 pending medical exam. At 8:00 p.m. on 3-6-85, father discovered baby lying face down on bed and not breathing; appeared stiff; called 911. Natural mother was in jail on drug charges at time of death. Presumed father successfully passed polygraph test; cause of death was ruled to be unknown; no criminal arrests made. Two-year old sibling removed permanently from home. DSS social worker disciplined with suspension and strongly reprimanded for failure to exercise good judgment and use proper social work practice in this case.

Case: #5, Black male infant

Born: March 26, 1985

Died: June 13, 1986

Legal Status: Child born prematurely (34 weeks) to a mother with a history of drug abuse; baby had positive toxicology screen for cocaine and was abandoned by mother in hospital. Both mother and father never again found. Child placed with shelter mother for one year; had cranial surgery in 9-85. DSS had filed for termination parental rights, but dropped upon child's death.

Cause of Death: Homicide. Extensive blunt trauma to head.

Case Summary: Child was placed in fost/opt home on 4-23-86 in allegedly unlicensed home in Oakland. Placement was arranged through a home-finding agency. Foster father was unemployed, receiving SSI and was considered to be incapable of handling own finances; was an ex-convict. Foster mother worked as a nurse's aide on graveyard shift; discovered to be a male transvestite. About 3:00 a.m. on 6-12-86, #5 was allegedly beaten about the head and body. Baby taken to hospital and from there transferred to another medical center where he died the following day from multiple traumatic injuries. Foster parents arrested for murder; case pending.

| | |
|---|---|
| Case: | #6, Black female infant. |
| Born: | January 15, 1986. |
| Died: | June 23, 1986. |
| Legal Status: | Placed in six-bed emergency shelter foster home at 12 days of age, under jurisdiction of DSS and Children's Home Society. |
| Cause of Death: | Pending; no history of serious illness. |
| Case Summary: | #6 was sixth child of mother long diagnosed as paranoid schizophrenic with postpartum psychotic episodes. Three other siblings also were dependents of court. #6 and sister, aged 1 1/2 years, placed in shelter care after several home visits by DPH and DSS indicated mother was incapable of caring for infants. #6 was a well baby and the cause of death is still unknown.<br><br>While no responsibility for the death is being fixed on the foster licensees, there are some unresolved questions regarding the appropriateness of care and first aid procedures at the foster home immediately preceding and following #6's medical crisis. The child was allegedly found by foster licensee at approximately 8:00 a.m. lying on her back with three covers over face and breathing shallowly. CPR and mouth-to-mouth resuscitation were applied. Responding paramedic reports that the resuscitation was inappropriate, was being applied with far too much force, and was potentially harmful. Initial medical report indicates full renal failure, apnea and seizures shortly after admission to ER. |

| | |
|---|---|
| Name: | #7, black female infant. |
| Born: | September 25, 1981 |
| Died: | November 30, 1981 |
| Status: | In emergency foster care pending dependency and placement hearings. |
| Cause of Death: | SIDS; infant was born with positive drug toxicity and metabolic disorder. |
| Case Summary: | #7 was fourth child of a woman whose other children had been placed in out-of-home care. Mother was long-time recipient of social services, was transient and had a history of narcotics use and incarcerations. #7 was placed in a husband-wife foster home after discharge from the hospital on October 16. Her health was always precarious and death was not considered suspicious. Placement procedures and foster parents' care of infant are not an issue in this case. |

| | |
|---|---|
| Case: | #8, white female toddler. |
| Born: | December 6, 1982. |
| Died: | July 17, 1985. |
| Legal Status: | Had been placed in home of prospective adoptive parents, under jurisdiction of DSS. |
| Cause of Death: | Ruled accidental drowning in bathtub; DSS reported to State DSS that cause of drowning was previously undiagnosed seizure disorder. Medical records known to the Committee specifically indicate no history of seizure disorder in #8. |
| Case Summary: | #8 was daughter of long-time client of social services departments. Mother was diagnosed muscular sclerosis with psychotic episodes. Prospective adoptive parents were known to and liked by a relative of #8, who encouraged the placement. #8 had thrived in the prospective adoptive home for several months at time of death. Death occurred when prospective adoptive mother left #8 unattended in bathtub for several minutes. |

| | |
|---|---|
| Case: | #9, Black female infant. |
| Born: | July 11, 1980. |
| Died: | March 31, 1981. |
| Legal Status: | In the care of foster mother, under DSS supervision. Record shows court ordered foster care placement on September 11, 1980. (Home was licensed for one child--#9's sibling--one year later, on September 3, 1981. Record does not reflect any license allowing placement for #9, although the court ordered placement of #9 as a foster child in the home.) |
| Cause of Death: | Death occurred subsequent to surgery to repair intestinal problems. Ruled natural. |
| Case Summary: | #9 and #9's siblings were considered by DSS to be "children with special medical problems and born with immunodeficiency problems and accompanying severe respiratory problems". #9 had spent first two months of life in UC Medical and had required surgery twice by her fifth month of life. The foster home in which #9 and one sibling were placed was not a therapeutic or medical needs home, and sometimes the foster mother required neighbors to babysit the children while she worked. Nonetheless, #9's pediatrician reportedly informed DSS that #9's care in the foster home was good and was not at issue in her death or in her medical supervision during her months in the foster home. |

| | |
|---|---|
| Case: | #10, Asian female infant |
| Born: | January 7, 1984 |
| Died: | January 9, 1985 |
| Legal Status: | Relinquished voluntarily by natural parents (S.F. residence) through CHS on 3-20-84; placed in foster home out of county on 1-16-84 until death. |
| Cause of Death: | Natural death. Heart failure after surgery for heart abnormalities; Downs' syndrome baby. |
| Case Summary: | Baby was born with Down's Syndrome and multiple congenital heart defects. Transferred to university hospital for last-chance surgery for large hole in A/V canal and other heart abnormalities. Child died of cardiac failure after surgery. Child was extremely well cared for by foster parents who have had Down's Syndrome babies in the past. Death was from natural causes. |

PERSONS INTERVIEWED BY COMMITTEE OR STAFF INCLUDE:*

EDWIN SARSFIELD, GENERAL MANAGER
Department of Social Services (C)

LILLIAN JOHNSON, PROGRAM MANAGER
Div. of Family and Children's Services
Department of Social Services (C, TA, SLP)

CRAIG McCABE, HEAD ATTORNEY
City Attorney's Office, San Francisco (C, TA, SLP)

CAROL GOSS, DIRECTOR (former)
Children's Home Society, San Francisco (JB, TA)

SUSAN SMITH, SOCIAL WORKER (former)
Children's Home Society, San Francisco (TA)

ALEKA CHASE, INTAKE WORKER
Children's Home Society, San Francisco (TA)

ANNA LYNCH, INTAKE WORKER
Children's Home Society, San Francisco (TA)

WILLIAM WHITE, INVESTIGATOR
Napa County Sheriff's Office (TA)

JOHN W. HAGERTY, DEPUTY DIRECTOR
State Department of Social Services (TA, SLP)

LOREN D. SUTER, DEPUTY DIRECTOR
State Department of Social Services (SLP, TA)

KATHY B. LEWIS, CHIEF
State Department of Social Services (SLP, TA)

ANN RICHARDSON, STAFF SERVICES MANAGER
State Department of Social Services (TA, SLP)

DORIS COLE, PROGRAM MGT. CONSULTANT
State Department of Social Services (SLP, TA)

DICK KUEST, CHILD ABUSE PREVENTION,
State Department of Social Services (TA, SLP)

GARY A. MAGEE, INVESTIGATOR
State Department of Social Services (TA)

*Initials after each name indicate whether the individual was interviewed by the Committee ("C") or by investigators.

PERSON INTERVIEWED CONT'D

ROBIN BRAAFLADT, INVESTIGATOR
State Department of Social Services (TA)

BEN PARTINGTON, CHIEF INVESTIGATOR
State Department of Social Services (SLP, TA)

STEVEN LEE MACK, MOBILE INTENSIVE CARE NURSE
Pineer Ambluance Service
Napa, Calfiornia (TA)

TED ALAN PETERSON, PARAMEDIC SUPERVISOR
Pineer Ambulance Service
Napa, California (TA)

AVERY A. BROWN, PARAMEDIC, REGISTERED NURSE
Pineer Ambulance Service
Napa, California (TA)

MARK I. SOLER AND MADELEINE DALE
Prospective Foster Parents, San Francisco (C, SLP, TA)

DREW PRIDDY, SOCIAL WORKER
Department of Social Services, San Fracisco (SLP)

TA/mc
74800